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Medical Ethics and Education for Social Responsibility*

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The physician, said Henry Sigerist in 1940, has been acquiring an increasingly social role. For centuries, however, codes of medical ethics have concentrated on proper behavior toward individual patients and almost ignored the doctor's responsibilities to society. Major health service reforms have come principally from motivated lay leadership and citizen groups. Private physicians have been largely hostile toward movements to equalize the economic access of people to medical care and improve the supply and distribution of doctors. Medical practice in America and throughout the world has become seriously commercialized. In response, governments have applied various strategies to constrain physicians and induce more socially responsible behavior. But such external pressures should not be necessary if a broad socially oriented code of medical ethics were followed. Health care system changes would be most effective, but medical education could be thoroughly recast to clarify community health problems and policies required to meet them. Sigerist proposed such a new medical curriculum in 1941; if it had been introduced, a social code of medical ethics would not now seem utopian. An international conference might well be convened to consider how physicians should be educated to reach the inspiring goals of the World Health Organization.

The fifteen years that Henry E. Sigerist spent in the United States, from 1932 to 1947, were years of deep economic depression and global war. Medical students and young physicians of this period were strongly receptive to Sigerist's message that medicine's goal was social, that its biological capabilities were only means to a social end—the restoration of the patient to social usefulness or, better yet, the prevention of disease [1]. This paper will explore the extent to which medical ethics and medical education have promoted this conception of the physician's role in society. Insofar as the doctor has failed to play such a role, how might medical ethics and education be modified?

Forty years ago Henry Sigerist delivered the Terry Lectures at Yale, under the title: *Medicine and Human Welfare*. With elegant simplicity he traced the historical development of society's concepts of disease, of health, and of the role of the physician. In concluding the last lecture, he said:

> The scope of medicine has indeed broadened. . . . No longer a shaman, priest, craftsman, or cleric, [the physician] must be more than a mere scientist. We begin to perceive the outline of a new physician. Scientist and social worker, prepared to cooperate in teamwork and in close touch with the people he serves; a friend and leader, he will direct all his efforts toward the prevention

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> of disease and become a therapist when prevention has broken down—the social physician protecting the people and guiding them to a healthier and happier life [2].

Like so much of Sigerist's writing, these words were meant to be partly a forecast based on past historical trends, and partly an inspirational call to work toward future goals. A review of health service developments in America and elsewhere these past forty years may cast light on the validity of this forecast, and also on the prospects of our reaching the stated ideal. These developments in health service, of course, have been propelled by forces in the whole fabric of political and economic affairs. All too often, the changed role of the physician has been wrought against his personal resistance and mainly because of overwhelming external pressures.

RESPONSIBILITY TO THE INDIVIDUAL PATIENT

For centuries, society defined the obligations of the physician solely in terms of his responsibilities to individual patients. Every medical student is familiar with the Code of Hammurabi 2000 B.C. under which the Babylonian surgeon was rewarded—or indeed punished—for the results of his efforts, depending on their outcome and the social status of the patient [3]. The Hippocratic Oath, despite its mysterious origins, is still sworn to by new medical graduates—perhaps mainly to forge a link with an ancient calling; yet its affirmations speak only of the doctor's maintenance of honorable relations with each patient, and of devotion to his teacher [4].

Medical licensure had its beginnings in the Middle Ages, and was linked to the standards of competence formulated by the newly founded universities. In 1140, the Norman king Roger decreed:

> Who, from now on, wishes to practice medicine, has to present himself before our officials and examiners, in order to pass their judgment . . . In this way we are taking care that our subjects are not endangered by the inexperience of the physicians. Nobody dare practice medicine unless he has been found fit by the convention of the Salernitan masters [5].

Aside from some generalities about good moral character, little more is to be found in the medical licensure laws of today. In the main, they are more specific about the required educational preparation and the examinations to be passed [6]. One searches in vain for provisions in the licensure laws about obligations of doctors to serve people in need, to cooperate with public authorities on the prevention of disease, always to put the patient's welfare above pecuniary gain, or any other doctrine defining medicine's social responsibilities.

Other formal influences on medical behavior arose not under law, but through the self-disciplinary rules formulated within the medical profession itself. With the rise of industrialism and mercantilism in the late eighteenth century, physicians inevitably became small businessmen. The problems emerging were those associated with the marketplace—"unfair practices" that could occur when physicians competed for patients. Thus in 1771 an English physician, Dr. Thomas Percival, began writing a series of essays on appropriate medical behavior. These were entitled:

(1) "Of Professional Conduct Relative to Hospital or Other Medical Charities,"
(2) "Of Professional Conduct in Private, or General Practice,"
(3) "Of the Conduct of Physicians to Apothecaries,"

(4) "Of Professional Duties in Certain Cases Which Require a Knowledge of Law" [7].

In the setting that generated these recommended standards of conduct, there was bound to be a mixture of precepts on truly ethical obligations of the doctor to the patient, along with advice on what might be best described as medical etiquette—or the proper relations of physicians with each other. To the present day, in most countries these so-called "Codes of Ethics" of the medical profession embody both types of rules of behavior.

The first Code of Ethics, issued by the American Medical Association at its birth in 1847, is based largely on Percival's essays [8]. Divided into three main parts, it defines the duties of physicians to their patients, to each other, and to the general public. The opening paragraph of the third part is worth quoting:

> As good citizens, it is the duty of physicians to be ever vigilant for the welfare of the community, and to bear their part in sustaining its institutions and burdens: they should also be ever ready to give counsel to the public in relation to matters especially appertaining to their profession, as on subjects of medical police, public hygiene, and legal medicine. It is their province to enlighten the public in regard to quarantine regulations . . . in regard to measures for the prevention of epidemic and contagious diseases; and when pestilence prevails, it is their duty to face the danger, and to continue their labours for the alleviation of the suffering, even at the jeopardy of their own lives.

The 1847 AMA Code of Ethics speaks also of "eleemosynary services" by the physician, adding that "justice requires that some limits should be placed on the performance of such good offices." After alluding to various abuses of such generosity, the text concludes that ". . . to individuals, in indigent circumstances, such professional services should be cheerfully and freely accorded." In the 1912 version of the AMA Code of Ethics, it is noteworthy that this discussion of the physician's obligation to serve the poor is reduced to: "The poverty of a patient and the mutual professional obligation of physicians should command the gratuitous services of a physician" [9].

Following this clause in the 1912 Code is a crucial new prohibition:

> It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession.

It was on the basis of this abstruse wording that, over the subsequent decades, medical societies in America justified opposition to most innovations designed to improve the access of people to medical care.

Deeds, of course, speak louder than words. Whatever may have been the lofty counsel of the ethical codes of physicians, we can learn more about the evolution of a professional sense of social responsibility—and the trials and tribulations along the way—by examining the actual relationships of physicians to the principal components of health care systems. In spite of the AMA Code's call for vigilance and

cooperation on public hygiene, its failure to call for *leadership* may not have been accidental.

RELATIONS TO PUBLIC HEALTH MEASURES

The important leadership in the origins of the public health movement in England came not from a physician, but from Edwin Chadwick—a wealthy public-spirited citizen of Lancashire—who reported in 1842 on the *Sanitary Conditions of the Labouring Population of Great Britain* [10]. Likewise, the first state public health agency in America resulted from the zealous efforts of a Boston bookseller, Lemuel Shattuck [11]. In later times, one need hardly mention the founding of milk stations—precursors of maternal and child health services—by New York philanthropist Nathan Strauss [12], or the origins of the mental hygiene movement by the remarkable Connecticut ex-mental hospital patient, Clifford Beers [13]. Of course, socially oriented physicians, like Edward Trudeau, Herman Biggs, or Thomas Parran, gave crucial leadership in other sectors of public health, but these were courageous men, not at all representative of their contemporaries in the medical profession.

Sixty years ago the posture of the main body of the medical profession in America toward public health advances was well illustrated by its reactions to the Sheppard-Towner Act of 1921; this was the first legislation for federal grants to the states in order to help them establish preventively oriented maternal and child health clinics [14]. In the aftermath of the Women's Suffrage Amendment to the Constitution in 1920, opposition to an "Act for the Promotion of the Welfare of Maternity and Infancy" could hardly be strong, but by 1926 the American Medical Association hardened its stand. Outright opposition was mounted in every state, and by 1929 the program had been destroyed. Not until the bleak Depression of the 1930s were federal grants to the states for maternal and child health, and also for other public health purposes, resumed in the Social Security Act of 1935. It is still not easy, however, to recruit physicians for service in MCH and other public health clinics, serving essentially low-income families.

During World War II, as a modest gesture for promoting military morale, the U.S. Children's Bureau proposed legislation to finance, for the families of enlisted military men, childbirth services and the care of the infant during its first year of life. Even the atmosphere of wartime patriotism did not inhibit the medical societies of almost every state from opposing this legislation; it was called another "entering wedge to socialized medicine," in spite of its provision simply to pay fees for the services rendered by private doctors in community hospitals [15]. Fortunately, the law was passed anyway, and it set the precedent for our current national program of general medical care for military dependents—the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

I will never forget the opposition encountered from local medical societies in my attempt to carry out my first public health job in 1941 in venereal disease control. Serological tests to detect hidden syphilis in young men were condemned as an invasion of the prerogatives of private medicine. Requiring medical reports of VD cases, in order to permit epidemiological contact-tracing, was branded an invasion of privacy. Establishment of local VD clinics, of course, was invariably fought in every way. My first venture into "health services research" compared nearby towns with and without VD clinics showing a higher, not a lower, rate of *private* VD patients (as reflected by laboratory reports) in towns with clinics, but this did little to neutralize

professional antagonisms. One might cite many more public health actions that could proceed only after overcoming the opposition of private doctors.

ATTITUDES TO SOCIAL FINANCING OF MEDICAL CARE

The attitude of the medical profession as a whole toward social measures to increase the economic access of patients to medical care has ranged from indifferent to cool to bitterly hostile. In early nineteenth century Europe, when mutual aid funds were formed to help low-income people cope with the economic burden of sickness (wage-loss) and medical care, the initiative was taken by workers. Doctors not flourishing with a carriage trade were glad to have these regular clients. After 1870, the same was true in the United States, where mutual benefit associations were founded, largely by European immigrant workers [16].

When voluntary medical care insurance was proposed in America on a large scale, however, the opposition of the medical profession became forthright. From 1915 to 1918 proposals for compulsory health insurance of low-income workers were introduced in several state legislatures, and for a transitory period they were even supported by the American Medical Association [17]. By 1920, in the postwar atmosphere of conservatism, the same ideas were branded as "Bolshevist." Then, in 1928, the Committee on the Costs of Medical Care, headed by Dr. Ray Lyman Wilbur, former President of the American Medical Association and Secretary of the Interior under President Hoover, began its epochal work. The 28-volume Report of this blue-ribbon committee clarified the vast and complex scope of the problems of medical care in the United States and, in 1932, made four major recommendations [18]. Most fundamental among these was advocacy of *voluntary*, not statutory or compulsory, insurance for medical care. This recommendation, and indeed the entire report, was greeted by the American Medical Association as "socialism, communism, inciting to revolution" [19]. At about the same time, the voluntary hospitalization insurance movement, later named Blue Cross, had its beginnings—only to be greeted with nearly equivalent hostility, as a "half-baked scheme." It was only when the incomes of doctors themselves began to suffer seriously from the massive Depression, that the private profession came to appreciate the value of voluntary health insurance [20]. In 1939, the California Medical Association organized the first doctor-sponsored health insurance plan, later called "Blue Shield"; insurance that would pay fees to private doctors was deemed preferable to a threatened expansion of county hospitals with physicians on salary [21].

The intransigent opposition of the American medical profession to *national* health insurance over the next decades is too well known to review for persons involved in the health care system. One should not overlook, however, the effect of the mere consideration by Congress of governmental health insurance proposals in stimulating the growth of voluntary health insurance, especially after World War II. Yet when government set out to remedy the major weaknesses of voluntary insurance—its deficient coverage of the aged and the poor, and the inadequate benefits for those covered—the medical profession joined with private insurance corporations and other business interests to oppose it vigorously [22]. Nevertheless, the dramatically obvious needs and the overwhelming support of the population led to the enactment in 1965 of Medicare and Medicaid.

The administrative provisions of these laws to meet medical expenses of the aged and the poor are highly permissive, and unfortunately American doctors and hospitals soon took advantage of them. Medical and hospital charges (prices) rose rapidly, unjustified services—yielding generous fees—were multiplied, and all sorts of

abuses developed [23]. In reaction, the government was compelled to establish mechanisms through which doctors could monitor each other, by way of a national network of Professional Standard Review Organizations (PSROs) [24], and even to set up a national office on "fraud and abuse." As costs continued to mount, state governments were forced to slow down the rise in fees payable for care of the poor, whereupon a growing proportion of doctors declined to see Medicaid patients at all [25]. It is noteworthy that, in its 1957 version, the AMA Code of Ethics no longer contains any reference to "gratuitous services" to the poor [26]. By 1976, even the generous fees of Medicare insurance for the aged no longer satisfied American physicians for most services; in that year U.S. doctors declined to accept "customary, prevailing, and reasonable" (CPR) fees for 54 percent of the services rendered [27]. This meant that they could charge whatever they liked but aged patients (usually of low income) could seek reinbursement only for 80 percent of the CPR fees.

Lest medical opposition to the social financing of health care be regarded as a peculiarly American phenomenon, one need only be reminded of the perennial conflicts between physicians and social insurance authorities in France, Germany, Great Britain, Japan, Australia, and elsewhere [28]. Doctors have not refrained from "strikes," or outright withholding of services from patients, in opposing the implementation of health insurance laws duly enacted by parliamentary bodies. Such action was threatened by the British Medical Association shortly before the effective date of the British National Health Service in 1948 [29]. Doctors in Saskatchewan, Canada, actually withheld all except emergency services for twenty-three days after the 1962 opening date of the Medical Care Insurance program in that province. Yet within six years legislation was enacted to cover all of Canada with similar insured services [30]. Between 1960 and 1968, no fewer than sixteen doctor strikes occurred in seven European countries, as part of medical resistance to health insurance operations [31].

MEDICAL EDUCATION AND PHYSICIAN SUPPLY

With respect to medical education and the supply of physicians in America, the social dynamics have been particularly complex. In the late nineteenth century, scientific advances were very rapid, but doctors were being trained at scores of mediocre schools. Abraham Flexner, educator but not physician, was appointed by the Carnegie Foundation to survey the situation, and his famous report of 1910 had enormous impact. The quality of medical education became vastly improved, both in its scientific content and in the use of full-time teachers [32]. Through a system of "grading" schools, the substandard ones would gradually be eliminated. Leaders of the medical profession embraced the report, and the AMA participated in the grading program.

But there was another side to the impact of the Flexner report. Medical education became highly technological, with little room for teaching about medicine's ultimately social role [33]. Everyone realized also that closing medical schools would reduce the nation's supply of doctors, but this was welcomed by the AMA, since the United States was regarded as having an "over-supply" [34]. The evidence for this cited by Flexner was that America had more doctors proportionately than several European countries, and many U.S. doctors had low incomes. Questions about the numbers and types of doctors necessary to meet the U.S. population's health needs were not even posed.

As was to be expected, the U.S. doctor-to-population ratio declined for twenty years after the Flexner report; then, from 1930 to 1960, the output of doctors barely

kept up with population growth. Meanwhile the steadily rising demands for medical care—due to greater public education, purchasing power, and other factors—could be handled only through vastly expanded training of nurses and other health personnel [35]. With federal subsidies of medical schools, the U.S. doctor-to-population ratio began to improve about 1960, but this was achieved only after overcoming the long resistance to such subsidies from the private medical profession [36]. Clarification of the nation's need for more doctors came, not from the medical profession, but from the U.S. Public Health Service—particularly through the work of one of its most courageous leaders, Dr. Joseph W. Mountin [37].

The enormous growth of medical specialization (currently about 85 percent of practicing U.S. doctors) with a resultant steep decline in generalists and primary care doctors, is another long-term consequence of the policies characterizing the post-Flexner era in American medicine [38]. The trend has been reflected in rising problems of patient access to primary care and spiralling demands on hospital emergency departments. The extremely high proportion of surgeons and surgical specialties in the United States (relative to other countries) has undoubtedly led to excessive rates of surgical operations [39]. It has also probably contributed to the avalanche of medical malpractice suits, in a magnitude not seen in any other country [40].

What has been the response of the American medical profession to these problems? Has it been to recommend actions which would reduce the training of surgical specialists and increase the output of primary care doctors? Not at all. It has been to encourage the training of various doctor-substitutes, known as "physician assistants" and "nurse practitioners" [41]. These personnel are principally intended to serve the poor in inner-city slums and rural areas, where primary care shortages have been very critical. By contrast, other industrialized nations—where specialization has developed to a reasonable degree and where close to half the doctors are engaged in primary care—have rejected these lesser trained personnel for primary care; instead, they have emphasized the further strengthening of general medical practice [42]. The Soviet Union stopped training "feldshers" some years ago, when its supply of physicians was deemed adequate. On the other hand, most European countries use trained midwives for normal deliveries—yielding a great saving of physician manpower. Yet, in spite of the superior maternal mortality record of these countries, most American obstetricians have opposed these effective health personnel for reasons that are not hard to guess.

A more socially sound response to the American deficiencies in primary care medicine has come from the U.S. Congress, which has provided financial inducement to increase residency training in primary care fields [43]. After many years of resistance from the dominant body of specialists in the American profession, a "specialty" status for family practice was established in 1968, in order to enhance the social standing and potential earnings of medical generalists [44].

ENTREPRENEURIALISM IN MEDICINE—A WORLDWIDE PHENOMENON

This may be enough information to support the conclusion that medicine in recent decades has become seriously corrupted with a spirit of entrepreneurialism. The poignant image of the devoted horse-and-buggy doctor of a century ago may or may not have been as generally valid as one might be led to believe [45]. But, in the current era, the lofty medical traditions of human service have clearly become eroded by essentially commercial objectives. While we have discussed mostly the American

setting—and commercialized medicine is probably more extreme in this bastion of free enterprise than elsewhere—the problem is by no means limited to the United States.

In Germany, where the social insurance concept was first applied to medical care in the 1880s, physician abuse of the fee system of remuneration has long been a problem [46]. Although more than 85 percent of the West German population is now covered by the mandatory insurance program, there are frequent complaints that the minority of private or voluntarily insured patients are treated more solicitously than the socially insured. A study in 1966 showed, moreover, that superfluous service by general practitioners was commonplace; thus, doctors seeing fewer patients per quarter-year gave more services per case, with the evident intention of elevating their earnings [47]. Unwarranted multiplication of office visits for minor illness has long been a widely recognized abuse in Japan's health insurance system; the general practitioner dispenses most medication, typically giving the patient only a two- or three-day supply so that he must return repeatedly for new prescriptions [48]. In the Belgian health insurance system, medical fees are frequently inflated beyond the officially approved level, and the rate of home calls, as compared to office visits, is inordinately high because the former command larger insurance fees [49].

The retention of fee-for-service payment of doctors under social insurance programs, in order to satisfy the medical profession, presents a constant regulatory challenge to public authorities. In Canada, where each of the ten provinces administers its own scheme, a whole spectrum of disciplinary strategies has been found necessary [50]. Tabulation of statistical profiles of each physician's pattern of practice is widely used, and deviant performance that cannot be justified is penalized in various ways. The province of Quebec has been led to be particularly rigorous in its controls; field audits of hospital medical records are regularly made, and the findings may lead to requiring consultations in all surgical cases of a deficient doctor, mandating postgraduate education, or suspending a doctor from the program entirely. Salaried remuneration of doctors, frequently used for hospital specialists, is associated with other abuses. In Sweden, excessive private practice after official hours caused such serious inequities that the government was forced to ban this "privilege" in 1972 [51], a policy adopted soon after by Norway. In the British National Health Service, limited private practice by salaried hospital consultants had long been allowed, despite the inequities it caused; under the current Conservative British government, these inequities are being aggravated through encouraging the sale of personal insurance to facilitate the purchase of private service by greater numbers of affluent people, who can afford to pay twice [52].

In Australia, the highly political private medical profession played a significant role in destroying an entire national health insurance program that had been legislated in 1974 [53]. After twenty years of conservative rule, a Labour Party government was elected in December 1972; soon a comprehensive national health insurance law was enacted. The Australian Medical Association, however, in league with the private insurance industry and other interests, so successfully obstructed the program's implementation that the Governor-General called a new election. The Labour Government fell, and promptly actions were taken to erode the operation of the new law step-by-step; by 1979, the Australian National Health Insurance program of 1974 had been completely dismantled [54].

Physician abuse and obstruction of social financing programs, designed to increase the equitable access of people to medical care, are not limited to the affluent industrialized countries. In Latin America, for example, it is customary for medical

care programs financed by social insurance to engage physicians on part-time salaries for two, three, or four hours of work per day. Similarly, physicians employed by Ministries of Health are paid part-time salaries. At the same time, almost all these physicians also have their private practices. It is widely recognized, however, that physicians frequently cut corners on the time devoted to official duties; the three-hour session, for example, is conducted in two hours, so that the physician may hasten off to his more lucrative private practice [55]. This sort of strategy of doctors, hostile to the National Health Service in Chile, became especially extensive under the Popular Unity government of 1970–73. It was generally regarded as deliberate sabotage which contributed to widespread public dissatisfaction and the eventual military overthrow of the duly elected Allende government [56].

In 1978, I had the opportunity to study the health services of Thailand for the World Health Organization. One of the most striking findings was that total health expenditures from private sources exceeded overall government health expenditures by a ratio of 2:1. Of the 66 percent of health monies spent privately, the largest share goes to paying private doctors. Yet most physicians are employed by government, full-time or part-time. The paradox is explained by the widespread tendency of official doctors to engage also in private practice; it is commonplace for them to advise any but the most indigent patients seen in public facilities to visit their private offices for "better care" [57]. In 1979, I had occasion to observe the same sort of behavior by salaried hospital consultants in the Caribbean island of Barbados. Since private earnings per hour were much greater than government salaries, all possible patients were referred to the consultant's private "clinic" outside the hospital [58].

Entrepreneurialism is found even in the medical services of the socialist countries. Publicly financed health care has been developed to a very high level in the Soviet Union and similar countries, but private practice has never been banned. As a result, people lacking confidence in the public system and having the money to spend may seek private care from a doctor after his official duty hours. In Poland, this pattern became so prevalent that it has been institutionalized through so-called "medical cooperatives," where doctors may work up to two hours per day after their public service. The fees are officially regulated but they must, of course, be paid by the patient privately [59].

PRESSURES TOWARD SOCIALLY ORIENTED MEDICAL BEHAVIOR

This recitation of medical behavior in the health care systems of America and throughout the world—behavior so often contrary to the best interests of patients, particularly the least fortunate members of any society—is surely enough to suggest the contours of a problem not merely in personal morality but in the social ethics of medicine. It is not so much the behavior of the doctor to the individual patient or the relationship of one doctor to another that is involved. It is the attitude, the practices, and the policies of doctors toward the total population that are involved or, more accurately, the medical profession's sense of social responsibility.

Despite the various observations about medical policies and performance made above, the fact is that a more equitable distribution of health service has gradually been approached in most of the world. This has seldom been due, however, to any socially oriented initiatives of physicians—indeed, it has usually been in spite of massive resistance from physicians. Greater degrees of health care equity have been achieved largely due to the demands of populations and the sophistication of many public leaders. These have brought changes in the structure and function of health care systems, so that their impacts are more socially just.

Thus, the extension of various mechanisms of social financing almost everywhere—principally through social insurance and general revenue support—has provided purchasing power for medical care irrespective of family incomes. The doctor need no longer be expected to give "gratuitous services" to the poor; social funds have been mobilized to pay him [60]. It is noteworthy that in most European countries, unemployed or indigent persons are covered under the same health insurance schemes as the self-supporting, so that the care they seek will not be tarnished by the demeaning stigma of charity.

Rural populations have always suffered handicaps in access to medical care—handicaps due to the lack of resources in rural regions, compounded by poverty that restricts the ability of rural people to use even the meager resources available. Many countries have tackled this problem by imposing a social obligation on every new doctor to work for a period of time in rural areas. This was done first in the 1920s by the USSR, where all new medical graduates were obligated to spend three years in a rural health post. In the 1930s, Mexico required a six-month period of rural "social service" as a condition of medical licensure [61]. Since then, most countries of Latin America, many in Asia—such as Thailand, Malaysia, and the Philippines—and several countries of Africa have required similar rural service, usually for one year. In the United States, the National Health Service Corps program constitutes a similar strategy, confined mainly however to relatively few physicians whose medical education has been financed by direct federal grants [62]. One wonders when such social obligation to serve population needs will be an automatic condition for medical licensure in all countries.

The intervention of governments in free market dynamics, in order to protect the health of people, has taken many forms. In the drug industry, where the profit motive has led to a long saga of human tragedies, governmental controls have become increasingly rigorous in the United States and elsewhere [63]. While only indirectly affecting the physician, such regulation restricts the choice of medications that a doctor may prescribe for his patient. The licensure of hospitals by public authorities, now required in virtually all countries, likewise regulates the conditions of facilities in which a doctor's patients may be treated [64].

Rules and regulations affecting the conduct of physicians in hospitals emanate from many sources beyond governmental licensure. In most countries, although not in the United States, physicians working in hospitals are essentially employees of the hospital's governing body. Most frequently, this is a unit of government, but it may be a religious group or some type of citizen board. The relationship, in any case, exerts influence on physician performance in many ways, designed essentially to protect the patient [65].

The whole pattern of remunerating physicians by a specified fee for each medical act, commonplace with or without systems of social financing, has long been recognized to create economic incentives that may be harmful to patients. This mechanism may, indeed, stimulate hard work, but at the same time it encourages the maximization of diagnostic and therapeutic procedures that can be superfluous and wasteful [66]. In Great Britain, the monthly payment of general practitioners by capitation—according to the number of persons on each panel—has avoided this problem since national insurance started in 1911 [67]. Specialists working in hospitals are paid by flat salaries in most countries, and pressures for slowing the rise in hospital costs are leading to the extension of salaried hospital doctors in the United States also [68]. Both capitation and salary remuneration obviously influence the practice incentives of physicians.

Perhaps the most significant effort to modify conventional fee-for-service payment patterns in the United States has been the national thrust to promote the growth of "health maintenance organizations" (HMOs). Formerly known as "group health plans" or "prepaid group practice," this concept—combining insurance with organizational responsibility for the total care of a defined population—was bitterly opposed by the private American medical profession for decades [69]. Even the 1938 conviction of the American Medical Association in the federal courts for "criminal conspiracy in restraint of trade"—because of efforts to obstruct the operation of such a group health plan—succeeded only in blunting but not in stopping private medical opposition to this innovative pattern of health service [70]. The endless rise in medical care costs, however, led even a conservative federal administration (under Richard Nixon) to back up the HMO idea in 1971, and Congress soon enacted legislation to subsidize the formation of new HMOs throughout the nation [71]. The HMO movement in the United States is one more instance where the initiative taken by groups of citizens—or, as we now usually say, consumers—has developed patterns of health care organization that inevitably modify the behavior of participating physicians. Although HMOs entail certain hazards, the evidence suggests that their performance, or more accurately the performance of physicians within them, exceeds that in conventional private medical practice, in terms of both economy and quality [72].

These, then, are just some of the principal strategies of government or civic groups to induce a greater sense of social responsibility in the physician. Countless actions have been taken by society to modify or constrain the conditions of medical practice, so as to reduce entrepreneurial objectives and achieve greater equity in the impact of medicine on people.

Is it not reasonable to inquire why so much of the influence for achieving social equity, altruism, and idealism has arisen from outside the medical profession and not within it? Why has so much social effort been required to counteract entrepreneurial behavior by physicians, to impose regulation and disciplinary measures which compel medical performance that is more beneficial for patients? Yet the answer really calls for another question: why should one expect the physician to behave according to values different from those that prevail in the society around him?

The principal guiding *ethos* of most of the world for several hundred years has been private profit—personal self-interest [73]. But this has not been the *only* precept on which modern societies are built. At the same time there have been countless movements for community welfare, for social solidarity to protect the least fortunate [74]. In part, the motivation has come from religion, from the belief that kindness and mercy bring rewards to the giver as well as the receiver. In part, it has come from the calculated efforts of each social order to maintain its stability, to resist overthrow by those who are discontent and enraged about their suffering. As Henry Sigerist has shown, social security was pioneered by conservative German Chancellor Bismarck not to launch a revolution but to prevent one [75].

Whichever philosophical rationale for humanitarianism one may prefer, the challenge to medical ethics is to influence physician behavior in the direction of enhancing concern for the well-being of the greatest proportion of people. Admittedly, behavior is bound to be influenced more by social circumstances than by formal teaching; a cooperative community setting will generate more cooperative behavior than a competitive jungle, regardless of moralistic litanies. Yet, insofar as moral teachings can influence behavior, what should they be? What should be included in a code of medical ethics clearly oriented toward social responsibility?

TOWARD A SOCIAL ETHICS OF MEDICINE

In the light of medicine's long historical development toward a goal of equity, I would suggest that a modern code of ethics should put its major emphasis on the doctor's social responsibilities. I do not imply abandonment of long-established precepts for a virtuous doctor-patient relationship, such as doing the patient no harm, respecting individual dignity, and protecting the confidentiality of medical communication. But all too many treatises on medical ethics, even in modern times, are limited to issues of this sort, along with precepts on sexuality, contraception, sterilization, and abortion, which are essentially part of the doctrine of particular religious creeds [76].

Worldwide developments toward achieving equity in health care, however, are seldom communicated to students in medical school. The post-Flexner era in American medical education, as noted earlier, has turned out mainly specialized technologists with little sensitivity to medicine's social role. Similar concepts have come to dominate medical education in most other countries [77]. What can be done to launch another Flexnerian revolution for training in the social, as well as the technical, functions of the doctor?

After revelation of the brutal behavior of physicians in Nazi Germany, who conducted lethal experiments on human beings, the world medical community established principles that might prevent repetition of such atrocities. These were set forth in the Declaration of Helsinki on Biomedical Research Involving Human Subjects [78]. In the same spirit, observation of worldwide social trends in health care, along with recognition of the many problems encountered in attempting to achieve health care equity, should lead to the formulation of a new "Ethical Code on Medicine's Social Responsibility." From the streamlined Code of Ethics formulated by the World Medical Association in 1948 in its Declaration of Geneva, I would retain only the opening clause:

> (1) I solemnly pledge myself to consecrate my life to the service of humanity [79].

The pledges to practice the profession with dignity, to respect one's teachers, to regard other physicians as brothers, and so on would find little justification in a code on social responsibility. In their place I would add the following:

> (2) I will do whatever I can to help my patient and the whole community to prevent disease or injury and to maintain good health.
> (3) I will respect the dignity of all persons, serving them in accordance with their health needs, and irrespective of their personal status or the pecuniary rewards forthcoming to myself.
> (4) Realizing the greater health problems of the poor, I will extend special effort to respond wholeheartedly to their needs.
> (5) Conscious always that the cost of health care is supported by the people, I will do nothing wasteful nor without reasonable scientific justification.
> (6) In spite of the personal pleasures of settlement in certain localities, I will serve the people where they live and work, and where society judges my skills to be most needed.
> (7) I will serve cooperatively with other health workers, in the interests of efficient and effective provision of health service.

(8) I will cooperate with public authorities in the implementation of health legislation that reflects the democratic decisions of the people or their representatives.

(9) With utmost effort I will attempt to keep myself well informed on advances in medical knowledge, to be capable of giving the soundest possible service to my patients.

(10) As a socially conscious citizen, I will be alert to health hazards of the environment, join with others to eliminate any such hazards, and do everything possible to advance the welfare of all people.

These ten pledges may sound utopian and could doubtless be improved in content and scope, but I hope that they convey a certain message. If the future physician is to be the "scientist and social worker" that Henry Sigerist envisaged, a far broader code of ethics must guide his behavior than that outlined in the existing Declarations of the World Medical Association, let alone the Principles of the American Medical Association.

But more important than a formal code of conduct that any person or association could compose, the *education* of the doctor should awaken in him a profound realization of his social responsibilities. In 1941, Henry Sigerist outlined "a program for a new medical school" [80]. He wrote:

> . . . whoever is aware of developments (in medicine and society) cannot doubt that a new type of physician is needed. . . . We still need, more than ever, a scientific physician, well trained in laboratory and clinic. But we need more: we need a social physician who, conscious of developments, conscious of the social functions of medicine, considers himself in the service of society.

Dr. Sigerist then outlined the details of a medical curriculum containing the historical, sociological, political, economic, epidemiological, and philosophical content that might be expected to train the needed "social physician."

In the intervening years, the health care systems in all countries have become increasingly organized, both in their economic foundations and their patterns of health service delivery. Yet now, in 1980, medical schools are still training physicians as though private, solo medical practice were still the norm everywhere. If the schools had heeded Henry Sigerist's plea forty years ago, an ethical code on the social responsibilities of the physician would follow naturally; it would simply sum up the concepts of medicine which had been taught.

The social physician can no longer be regarded as an ethereal ideal of scholars and dreamers. He or she has come to be expected by people everywhere. For health care is not like other goods and services in a community or nation. Inequalities may be long tolerated in the clothing, the shelter, the transportation, the recreation, or even the range of foods that a society allocates to its people. But for the direct preservation of life and health, nations at all points on the political spectrum take actions with far more sweeping social impact. In the 1978 Conference of Alma Ata, sponsored by the World Health Organization and UNICEF, official representatives of 150 nations declared unanimously that:

> A main social target of governments, international organizations and the whole world community in the coming decades should be attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life [81].

Implementation of this Declaration will obviously require the utmost effort of many beyond the world's physicians. But the physician must obviously play a key role, as leader, as catalyst, as cooperative citizen. The urgency is now greater than ever. Today's world population is approximately double what it was when Henry Sigerist called for the training of social physicians. The poor and destitute people on earth have increased even more.

To train the needed social physicians, is it not necessary for an agency such as the World Health Organization to convene an international conference on this challenge? The medical schools of all nations must be inspired to train physicians who will be aware of the social realities of health and disease, and of the doctor's place in the great social movements everywhere toward implementing health care as a human right. Only then can we expect tomorrow's physicians to be capable of serving mankind in the role that Henry Sigerist envisaged.

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